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ABSTRACT

Research has indicated that premature termination of therapy is sometimes due to a conflict in goal and outcome expectations between therapists and family members of clients. The present study requested both therapists and parents of child clients to complete questionnaires to determine if there is congruence between therapist and parental expectations. The questionnaire was designed to measure the similarity in expectations for both parties or if lack of congruence is present that may possibly lead to premature termination of therapy for the child client. Also included in the study were responses from adult clients and therapists of adult clients. Within subject t-tests of a sample of 63 parents, 18 therapists, and 43 adult clients produced significant findings. Therapists and parents of child clients attached greater significance to the behavior change sub-scale, while adults rated the five sub-scales as equally important. Appendix A contains the Parent Attitude Questionnaire with a discussion of "Parents' Motivations for Seeking Treatment for Their Children." Appendix B provides the Client Attitude Questionnaire and a discussion of "Clients' Motivations for Seeking Treatment." More than 130 references are listed. (Author/EMK)

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Training Therapists about Client Expectations of Psychotherapy

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Abstract

Research has indicated that premature termination of therapy is sometimes due to a conflict in goal and outcome expectations between therapists and family members of clients. The present study requested both therapists and parents of child clients to complete questionnaires to determine if there is congruence between therapist and parental expectations. The questionnaire was designed to measure the similarity in expectations for both parties or if lack of congruence is present that may possibly lead to premature termination of therapy for the child client. Also included in the study were responses from adult clients and therapists of adult clients. Within subject t-tests of a sample of 63 parents, 18 therapists, and 43 adult clients produced significant findings. Therapists and parents of child clients attached greater significance to the behavior change sub-scale, while adults rated the five sub-scales as equally important.

Why do parents seek psychotherapy for their children? Although this knowledge would seem fundamental to the development of successful helping strategies, relatively little empirical research has addressed this issue. The previous research data has contributed to our current knowledge of consumer satisfaction with child psychotherapy; however, data has rarely been collected to analyze parental expectations for their child's treatment.

Critics of various schools of therapy have long argued that treatments that fail to address specific concerns of parents of child clients may be coherent conceptually, but of limited practical value. Premature termination and attrition from therapy outcome studies have often been attributed to treatments value to conform to parents' expectations of child psychotherapy, although parents who terminate their child's treatment prematurely have rarely been interviewed to ascertain their exact reasons for departing.

As consumers, we want to be satisfied with the quality of the products or services we are spending money to obtain. In order to ensure our satisfaction, consumerism has provided an abundance of product alternatives from which to choose. When the thought of product choice comes to mind, tangibility usually accompanies that thought; but, as consumers we have an array of intangible services that hopefully enhance lifestyle. This intangibility may affect the ability to accurately measure its quality. One of these consumer goods is child psychotherapy. What is the best way to measure the success of therapy given to children? Some of our measurements would look at therapist flexibility, pathology change, behavior improvement, and parent perception of child improvement. The production of true results can be quite a challenge as demonstrated by some studies

designed to measure the satisfaction of consumers of mental health services. Depending on the definition used for consumer satisfaction which can be construed in a very broad sense, it would be a safe assumption to conclude that parents of antisocial children would stop pursuing treatment if they are not finding a substantial behavioral change in their child. It is possible to equate the parental drop-out rate with dissatisfaction of the services provided while at the same time stating that this is a very simplistic view; there can be a myriad of other economic, social, familial, and personal reasons why parents would choose to end treatment before completion. It can also be said that all of these other reasons aside, if the treatment was outstanding the parent would most likely be motivated to continue until completion.

One study investigated the reasons for termination of mental health treatment prior to completion of the program. The study was initiated to help families with children who exhibit severe antisocial behavior (Kazdin, 1987; Miller & Prinz, 1990; Patterson, 1986). Using a multiple gating strategy, the sample included 4 to 9 year old boys from 147 families meeting the criteria for treatment. Nine therapists were used in the study consisting of 6 women and 3 men, all possessing master's degrees in clinical or school psychology, as well as 2 years of supervised family experience (Miller & Prinz, 1994). The families were randomly assigned to an EFT (Enhanced Family Treatment) or an SFT (Standard Family Treatment). SFT is a conventional approach to therapy for parent-child interactions. EFT combines the approaches of SFT with an additional focus on issues the parent is confronting. At the outset, the advantages of both approaches were reviewed. If the therapist were to focus only on parent-child interaction, the effectiveness might be reduced because parents' issues would not be resolved.

Conversely, some parents might feel uncomfortable with the focus on themselves (Miller & Prinz, 1990; Wahler & Dumas, 1989). In either of these situations, without knowledge of the parents' feelings, it might be an incentive to discontinue treatment. "Measures included the following: (a) parent and teacher reports on Achenbach's Child Behavior Checklist; (b) parental report of personal adjustment on the Symptom Distress Checklist-90 (SCL-90; Derogatis, Rickels, & Rock, 1976), marital adjustment on the Dyadic Adjustment Scale (DAS; Spanier & Thompson, 1982), and social support on the Arizona Social Support Interview Schedule (ASSIS; Sandler & Barrera, 1984); (c) Hollingshead four-factor socioeconomic status index."

Dropout rates for each program were as follows: 29.2% for EFT and 46.7% for SFT. Dropouts were interviewed by phone to determine their reasons for discontinuation of treatment. Situational factors were cited for the reason more frequently for SFT (73%) versus EFT (47%), but dissatisfaction with intervention was cited much more frequently for SFT (26%) versus EFT (6%).

These results indicate parents need to be provided with supportive services for personal life issues as well as their socially maladaptive children. Giving parents a way to release frustration is imperative for children to continue to receive treatment. It also lends support to the broader issue that consumer satisfaction does indeed make a difference in child therapy. It is important for parents to be satisfied with the treatment of their children and part of this satisfaction may involve providing services to both children and parents.

Due to the importance of treatment completion, it is necessary to discover the specifics which lead to premature termination. The rate of dropout among families

receiving child therapy has been estimated at 40-60% (Kazdin, 1996a; Wierzbicki & Pekarik, 1993). It is assumed that there are barriers to the continuation of treatment such as socioeconomic status. We have already established that there may be issues related to satisfaction with therapists' services. Do all participants who experience barriers to treatment drop out regardless of the level of satisfaction? Premature termination can be detrimental for the families who need the service but there are broader implications. The accuracy of research is affected by the number of dropouts. Sample size and sample characteristics are altered making generalization difficult. Therefore, it is essential to measure the causes of premature termination of treatment for individual and statistical purposes.

The current research identifies social characteristics contributing to premature termination of treatment. "Socioeconomic status, minority group, high levels of stress and family dysfunction, and difficult living circumstances (e.g., single-parent families) are among the salient factors" (Armbruster & Kazdin, 1994; Gould, Shaffer, & Kaplan, 1985). Some other less studied issues relating to drop out are "parental stress and life events, parent psychopathology, and severity of child externalizing problems" (Kazdin, A.E., Holland, L., & Crowley, M., 1997). However, several of these characteristics may produce more than one barrier to receiving treatment, so it is difficult to determine what factor of socioeconomic status, for example, is actually causing the decline. Other factors unrelated to situation may also be involved, such as the quality of therapy and the client-therapist relationship.

The study of premature termination of therapy was designed to test three main hypotheses using a barriers to treatment model which emphasizes not only personal

factors but also the experience in the therapeutic setting: "(1) Family, parent and child factors identified at intake assessment would predict dropping out of treatment, (2) barriers to treatment would predict the rate of drop out, (3) barriers to treatment will increase the rate of drop out incrementally beyond the more fundamental causes of drop out mentioned earlier" (Kazdin, A. E., Holland, L., Crowley, M., 1997). Of the 242 individuals who participated in the study, 146 completed the program, and 96 dropped out of the study.

The findings indicated that perceived barriers to treatment, both fundamental and those related to treatment, perceptions of the treatment process itself, and relationship of parent with therapist all influenced the premature termination of therapy. These results should be tempered with some limitations. The sample included children who were referred to the program and included only cognitive and cognitive-behavioral clinics so diversity in treatment cannot be generalized. Also, responses were collected subsequent to treatment; some recall bias may have influenced results. Finally, it has been established that parents make the decision to continue in treatment, but this ignores the possibility that the child may influence directly or indirectly the final decision of the parent to continue or terminate treatment.

Effects of Managed Care on Studies of Satisfaction

The advent of managed care has brought a new fervor for satisfaction measures in the field of behavioral therapy. Consumers and providers of care need feedback on the effectiveness of therapy. Mental health professionals can point to studies that demonstrate that treatment is beneficial but these studies are increasingly being challenged for more relevant data (e.g. Casey & Berman, 1985; Smith, Glass, & Miller,

1980; Weisz, Weiss, Alicke, & Klotz, 1987). Most study results are based on lab findings, not those done in the field. Mental health researchers have been challenged on the applicability of lab settings to those in the field (see Hoagwood, Hibbs, Brent, & Jenson). This has provided a heightened awareness of the need to obtain results from those in therapy. The few studies that *have been* conducted provide little consistency in results for adults or children and adolescents (Weisz, Weiss, & Donenberg).

A field based study must take into account constructs of interest and methods. Constructs of interest refer to what is being measured and methods refer to how it is being measured. Most evaluations of effectiveness use pathology change as a barometer. "Clinical effectiveness is determined by (a) the extent to which symptoms decrease or functioning increases, and (b) whether scores for a treated group are significantly better than scores for a comparison group (Lambert, Salzer, & Bickman, 1998)." Some obstacles to getting at the information required are cost, data collection methods, and the factors to measure pathology change. Behavioral Health Organizations find that satisfaction and improvement are the best indicators of effectiveness and because most of the studies would be funded by the BHO's, the choice of method would also be determined by the BHO.

Unfortunately, BHO's are not only collecting the data to provide measurements of satisfaction to consumers but also to classify what should and should not be considered a mental illness in need of treatment. A mental illness by definition may be difficult to organize, categorize, and classify. The DSM, for this reason, is in a state of continual change. It should be mentioned as well that some therapists resist the quantification of success rates. This is a healing profession and as with any medical doctor, diagnosis and

treatment may take extended periods of time. But if a physical illness cannot be identified, doctors do not give up; they continue searching for a cause based upon symptoms. It is no different for therapists and why should it be?

The problem with using satisfaction as the primary determinant of pathology change is the lack of correlation between various studies that link satisfaction with pathology. Some studies show moderate correlation, yet most do not demonstrate consistent results (Attkisson & Zwick, 1982). Additionally, the level of agreement between ratings by therapist and client have varied greatly (Weiss, Rabinowitz, & Spiro, 1996). Also, self report questionnaires must be differentiated for parent and child. The reason for this inconsistency has been cited as method variance.

A study was designed to compare the effectiveness of traditional therapy services with a quasi-experimental continuum of care design. In designing the study, a multitrait-multimethod model was used to achieve consistent results.

> Informants included the client, a parent, and a trained interviewer, with additional data from teachers and providers. For the present study, only adolescent clients were used because younger children did not fill out self-reports...In the present study, we examine relationships among pathology change (as reported by adolescents, parents, and trained interviewers), client satisfaction (as reported by adolescents and their parents), and perceived improvement (reported by parents).

Three hypotheses were tested: (1) Using different informants would provide a greater match to the data than using a shared method, (2) pathology change and satisfaction measures should be kept separate, (3) parent reporting of perceived improvement will be more indicative

of satisfaction than pathology change (Lambert, Salzer, & Bickman, 1998).

The results of the study support the first two hypotheses. It is necessary to distinguish between symptom change and satisfaction as well as maintaining the distinctions between the responses of the interviewer, the parent, and the adolescent. The third hypothesis needs to be retested. Reports of parent perceived improvement were measures more so of satisfaction than pathology change. On the contrary, reports from adolescents of satisfaction were highly correlated with pathology change.

Collaboration and Family Satisfaction

Keeping in mind that the relationship of parent with therapist influences premature termination of therapy, one study by Dechillo, Koren, and Schultz examined the relationship between the collaboration of caregivers and mental health care professionals and family satisfaction. DeChillo, et al (1994) noted earlier studies that found family members of individuals with mental health issues unhappy with the services provided to them by professionals in the field. The dissatisfied family members felt as though they were being blamed for the problems of the individual in need of services and that their needs were not being met by the mental health care providers (Grunebaum, 1984; Hatfield, 1982; McElroy, 1987; Spaniol, Jung, Zipple, & Fitzgerald, 1987). In order to investigate the numerous reports of family dissatisfaction, DeChillo et al pointed to four studies (Benheim & Switalski, 1988; McElroy, 1987; Smets, 1982; Spaniol, Zipple, & Fitzgerald, 1984) which explored the relationship of mental health care professionals and family members of mental health patients. It was discovered that there were two main factors contributing to family dissatisfaction: the lack of family involvement in the treatment of the patient and disagreement between the health care

professional and family members on what treatment was best for the individual in need (DeChillo, Koren, & Schultz, 1994). Studies suggest that patient outcome could be improved if there was collaboration among the patient's family members and those in charge of providing mental health care (DeChillo, Koren, & Schultz, 1994).

DeChillo et al (1994) define collaboration as "two or more parties working together in pursuit of a common goal." In 1993, DeChillo conducted a survey of family members of adult patients on a psychiatric unit to appraise collaboration. Studying the contributing factors of collaboration and their effect on the patient's outcome, DeChillo found the strongest predictor of collaboration was the attitude of the social worker on the issue of family involvement (DeChillo, 1993). One point that was stressed in DeChillo's prior study was the importance of the identification of a common goal between family members of the patient and the social worker (DeChillo, 1993).

In their recent study, DeChillo et al (1994) investigated elements of collaboration by having 455 family members of children with emotional disorders complete a questionnaire intended to measure eight components of collaboration: (1) joint decision making and planning; (2) locating and developing services; (3) funding services; (4) evaluation based on feedback from family; (5) conveying a caring attitude; (6) sharing information; (7) recognizing the family as a resource, and (8) recognizing limits of the family. Caregivers were given one of two questionnaires (one asked the family member to complete the form with regard to a professional in the field he or she felt was easiest to work with; the other was to be filled out with regard to a professional the caregiver felt was most difficult to work with). The study recognized four key elements of collaboration: supportive relationships, which refers to the feeling of partnership between

the professional and caregiver; practical service arrangements, meaning the financial aspects and the coordination and development of services; information sharing, such as the explanations and communication efforts put forth by the professional to the family member; and a flexible, shared approach to measuring failure or success, the professional taking seriously and working with feedback from the caregivers (DeChillo et al, 1994). DeChillo et al found "a very strong relationship between satisfaction and collaboration" (1994). This is consistent with prior research revealing the importance of congruence between therapist and family members of the patient.

Parental Satisfaction with Inpatient Mental Health Services

In an effort to address what is considered to be a neglected area of research, a study was conducted at a state psychiatric center in Staten Island, New York concerning parental satisfaction with mental health care services (Byalin, 1993). Using the Client Satisfaction Questionnaire (CSQ), which can be measured on a standardized scale (Attkisson & Zwick, 1980), parents of recently discharged children and adolescents between the ages of 12 and 18 were asked to give their responses with regard to the services their children received while they were patients in the psychiatric center (Byalin, 1993).

Byalin (1993) points out that there has been little attention and priority given to parental and family satisfaction with services in the mental health field with the exception of a noteworthy 1978 study in which Woodward and Associates researched consumer satisfaction with brief family therapy (Woodward, Santa-Barbara, Levin, & Epstein, 1978). Byalin's study was originally created to monitor and evaluate the quality of this particular psychiatric facility. The thought behind this was that parental

empowerment, which the program was targeted to increase, would equate to parental satisfaction; therefore, parental satisfaction was used as the measurement tool (Byalin, 1990).

With 53 questionnaires sent out and only 15 questionnaires returned completed, the research in many ways was a disappointment. However, some promising ideas were discovered. For example, Byalin notes that the questionnaire used for this study would be a successful tool in providing ongoing evaluations of the program. It was also found that for the most part, parents were satisfied with services with the exception of one Area--parents indicated from the responses on the questionnaire that they were unhappy that certain issues, not considered to be psychiatric, were not taken care of before their child was discharged. This led to the conclusion that staff members may be less responsive or less attuned to consumer needs they do not consider to be "psychiatric" (Byalin, 1993).

Prior research has provided some general conclusions that can be summarized. Parental satisfaction is a crucial factor in preventing premature termination of child psychotherapy. Many variables can influence satisfaction including situational status, parent-therapist relationship, and contact within the behavioral treatment setting. Most studies are either based on pre or post assessments, but not both. Future studies need to focus on pre-treatment measurements of expectations, as well as post treatment satisfaction.

The results of Reynolds, Ogiba, and Chambliss' (1998) study indicated that therapists and adult clients were largely congruent in their goal objectives. However, Soley, Hooper, Marshall, and Chambliss (1998) , using a similar between subject design,

found a disparity between therapist expectations and the expectations of the parents of child clients. In the Soley et al study, parents of child clients rated normalization more highly than therapists. This suggests the possibility that therapists may have misperceived the objectives of parents bringing their children to therapy. Nonetheless, a problem with the Soley et al study was that its between subject analyses included a scaling confound; between group difference in use of the rating system may have produced misleading findings.

In order to remedy this problem, the original Soley et al study was reanalyzed using a within subject design. Using the within subject design we were able to assess the relative treatment priority for the different constituencies.

Method

Therapists from a variety of local treatment centers were asked to record their responses on a questionnaire with 29 (Likert-format) items concerning parent's attitudes when bringing their child to therapy (See appendix A). The therapists were asked to answer the questions as they believed a parent would answer it when bringing his or her child to therapy.

A sample of parents, solicited from child treatment sites, were asked to complete the same questionnaire as the therapists. Additional participating parents were contacted at a local fast food restaurant on the weekend while they were watching their children play in the play area.

Responses were obtained from 12 therapists, consisting of 7 males and 5 females, and 67 parents, consisting of 44 females and 22 males. The mean age of the therapists was 40.92 years, with an average of 14.42 years of experience in the mental health care

field. The mean age of the participating parents was 39.45 years. Approximately 67% of the therapists and 80% of the parents contacted actually completed the questionnaire. Both the therapists and the parents were from the suburbs of Philadelphia.

Thirty percent of the participating parents reported actually having a child in therapy. The remaining parents answered the questionnaire hypothetically, based on what their expectations would be if their child ever needed therapy.

Previous research, conducted by Reynolds et al (1998), had therapists of adult clients, as well as adult clents, complete a questionnaire with 27 Likert-format items concerning clients' attitudes toward therapy (see Appendix B). Therapists were randomly selected from telephone directories, while prospective psychotherapy clients were obtained by anonymously surveying undergraduates at a small Liberal Arts college. Responses were obtained from 7 therapists of adult clients and 42 prospective clients.

A separate demographic questionnaire was provided for the therapists and for the parents of prospective and actual clients, as well as for the adult client sample. The therapist of child client's demographic questionnaire consisted of 8 items, while the therapists of adult client's demographic questionnaire consisted of 6 items. The parent's demographic questionnaire consisted of 6 items, while the adult client's questionnaire consisted of 4 items. All respondents were assured of anonymity.

Results

Relevant items were totaled for each subject, yielding five sub-scale scores assessing the treatment objectives: Normalization, Analysis, Decision-making, Behavior Change, and Affect Change. Within subject t-tests were used to compare the five sub-scale scores of all respondents considered together, the therapists, parents of child clients, and adult

clients.

When all subjects were considered together, behavior change scores were significantly higher than all of the other sub-scale scores. Affect change and decision-making assistance were rated comparably; scores for both were significantly higher than those for analysis ($p < .05$) and normalization ($p < .001$). Analysis scores were significantly higher than those for normalization ($p < .05$).

Among therapists, t-tests showed results largely paralleling those of the total sample. Behavior change scores were significantly higher than all others, but more similar to affect change ($p < .01$) and decision-making ($p < .01$) than analysis ($p < .001$) and normalization ($p < .001$). Affect change and decision-making were rated similarly, and both had higher scores than analysis and normalization. Analysis was rated higher than normalization ($p < .05$).

Like the sample of therapists, within subject t-tests for parents of child clients yielded results similar to those of the entire sample. Behavior change was rated more highly than all other sub-scales, including decision-making ($p < .04$), normalization ($p < .001$), and analysis ($p < .001$), but was similar to affect change. Affect change was rated as more of a priority than both analysis ($p < .001$) and normalization ($p < .001$), while decision-making assistance was considered more important to parents than analysis ($p < .003$) and normalization ($p < .002$). Normalization and analysis were rated comparably.

Comparison of adult clients' sub-scale scores showed no significant differences among them (see table).

Table 1
Goal Objectives Means and Standard Deviations

	Normalization	Analysis	Decision-Making	Behavior Change	Affect Change
All Subject	12.97 (3.82) N=126	13.56 (3.64) N=125	14.24 (3.79) N=127	15.05 (3.68) N=125	14.38 (3.90) N=125
Therapists N=18	11.44 (3.01)	12.67 (3.66)	14.39 (3.68)	16.67 (2.87)	14.89 (3.34)
Parents of Child Clients N=63	14.31 (3.34)	14.33 (3.78)	15.44 (3.52)	16.37 (2.73	16.02 (3.23)
Adult Clients N=43	11.58 (4.12)	12.79 (3.21)	12.35 (3.54)	12.40 (3.81)	11.74 (3.65)

Discussion

Within subject analyses showed the relative importance of therapeutic objectives of the various respondent groups. When all respondents were combined, what emerged was a view of therapy focused first on behavior change, next on affective improvement, and help with decision-making, with less emphasis on understanding causes of problems and less still on normalizing experiences.

Among therapists, behavior change was the clear treatment priority. Analysis was seen as less important than affect change and decision-making assistance. Therapists saw normalization as least important of all the objectives. The parents of child clients saw behavior change as having priority over the other goal objectives--just as the therapists had rated it. Affect change and decision making, although more important to parents than normalization and analysis, was rated as less important than behavior change. From this information, it would seem that therapists are quite in tune with the parents of their child clients.

Adult clients seemed to value all of the five therapy objectives equally. Unlike therapists and parents of child clients, they appeared to see normalization and causal understanding (analysis) as being as important as symptom reduction and decision-making assistance.

It is possible that today's therapists may spend too much time on the behavior symptom relief of adult clients in an attempt to over correct for all of the years that therapy focused only on the analysis and normalization aspects. It is important for therapist, especially when dealing with adult clients, to avoid overcorrection and allow some time to downplay the need for behavior change.

Future studies are needed with a larger sample of therapists and parents of children who are actual, rather than prospective clients. Few of the parents who completed questionnaires (30%) had actual first-hand experience with therapy. In addition, results from this study analyzed pre-treatment expectations; future studies will need to evaluate the same sample for pre and post-treatment outcomes.

Appendix A

Parent Attitude Questionnaire (PAQ)

Please share your reasons for bringing your child to treatment by responding to the following items. (1=not at all 2=somewhat 3=very true 4=extremely true)

1.____I hope therapy will increase my child's understanding of why he/she does things.
2.____I hope my child discovers that his/her feelings aren't unusual.
3.____I hope my child will feel less anxious and depressed.
4.____I want my child to make the right choice about what to do.
5.____I want my child to find out if he/she has a serious problem.
6.____I want my child to know the reasons behind his/her actions.
7.____I hope my child learns how to be more effective in relating to others.
8.____I want my child to have more confidence that he/she can do things.
9.____I want my child to learn how to make better decisions.
10.___I would like my child to understand how the past influences him/her.
11.___I would like my child to learn to be more assertive.
12.___I want my child to feel more positive about himself/herself.
13.___I want my child to learn how to handle situations more competently.
14.___I hope my child learns to be more honest with himself/herself.
15.___I would like my child to learn how to relax and have more fun.
16.___I want my child to learn whether others have problems like his/hers.
17.___I want my child to learn how to prevent becoming depressed.
18.___I would like my child to receive practical advice about a choice he/she is facing.
19.___I hope my child figures out what makes him/her tick.
20.___I want my child to get along better with his/her family.
21.___I would like my child to know that he/she is not the only one with this problem.
22.___I would like my child to receive help deciding what to do with his/her life.
23.___I want my child to learn how to keep from getting too angry.
24.___I want my child to figure out the course that will make him/her most happy.
25.___I want my child to find out if his/her problems are common.
26.___I would like my child to receive medication to help him/her function better.
27.___I hope therapy will increase my understanding of why he/she does things.
28.___I hope to learn how to respond more effectively to my child.
29. Has your child actually been in therapy?_____

Parents' Motivations for Seeking Treatment for their Children

The Parent Attitude Questionnaire (PAQ) was developed to assess the reasons parents seek the help of a psychotherapist for their child. It was designed to measure five different motivations for entering treatment, and is intended for use in both research and as a tool for clinicians in deciding how to structure their treatment.

The following shows the five factors and the items with the highest loadings on each of these factors. The 25 scale items were selected from an original pool of 40, on the basis of a factor analysis conducted on data from a sample of 140 therapy clients obtained over a period of four years.

Factor analytic research can be used to collapse scales, reducing items without any significant loss of information. Shortened forms impose less of a burden on the recipients, and are therefore expected to yield higher response rates. On-site evaluation provides clinicians with immediate feedback on their clients' expectations of treatment.

Normalization

I want my child to find out if she/he has a serious problem.

I hope my child discovers that his/her feelings aren't very unusual.

I want to my child to learn whether others have problems like his/hers.

I would like my child to know that he/she is not the only one going through this.

I want my child to find out if his/her problems are common.

Analysis

I hope therapy will increase my child's understanding of why he/she does things.

I want my child to know the reasons behind his/her actions.

I would like my child to understand how the past influences him/her.

I hope my child figures out what makes him/her tick.

Feelings

I hope my child will feel less anxious and depressed.

I want my child to feel more positive about himself/herself.

I would like my child to learn to how to relax and have more fun.

I want my child to learn how to prevent becoming depressed.

I want my child to learn how to keep from getting too angry.

Decision-Making

I want my child to make the right choice about what to do.

I want my child to learn how to make better decisions.

I would like my child to receive help deciding what to do with his/her life.

I would like my child to receive practical advice about a choice he/she is facing.

I want my child to figure out the course that will make him/her most happy.

Behavior Skills

I want my child to learn how to handle situations more competently.

I want my child to have more confidence that he/she can do things.

I would like my child to learn to be more assertive.

I hope my child learns how to be more effective in relating to others.

I want my child to learn to get along better with his/her family.

Appendix B

Client Attitude Questionnaire (CAQ)

Please share your reasons for coming to counseling by responding to the following items.
(1=not at all 2=somewhat 3=very true 4=extremely true)

1. ____I hope therapy will increase my understanding of why I do things.
2. ____I hope to discover that my feelings aren't unusual.
3. ____I hope to feel less anxious and depressed.
4. ____I want to be able to make the right choice about what to do.
5. ____I want to find out if I have a serious problem.
6. ____I want to know the reasons behind my actions and feelings.
7. ____I hope to learn how to be more effective in relating to others.
8. ____I want to have more confidence that I can do things.
9. ____I need help in learning how to make better decisions.
10. ____I need help in understanding how my childhood influenced me.
11. ____I need help in learning how to be more assertive.
12. ____I want to feel more positive about myself.
13. ____I want to learn how to handle situations more competently.
14. ____I hope to learn how to be more honest with myself.
15. ____I need to learn how to relax and have more fun.
16. ____I want to learn whether other people have problems like mine.
17. ____I want to learn how to prevent becoming depressed.
18. ____I need some practical advice about a choice I'm facing.
19. ____I hope to figure out what makes me tick.
20. ____I want to learn how to get along better with my family now.
21. ____I need to know if I'm the only one going through this.
22. ____I need help in deciding what to do with my life.
23. ____I need to learn how to keep from getting too angry.
24. ____I want to figure out the course that will make me most happy.
25. ____I want to find out if my problems are common.
26. ____I need to receive medication to help me function better.
27. Other things I hope to get from treatment:_____

Clients' Motivations for Seeking Treatment

The Client Attitude Questionnaire (CAQ) was developed to assess the reasons clients seek the help of a psychotherapist. It was designed to measure five different motivations for entering treatment, and is intended for use in both research and as a tool for clinicians in deciding how to structure their treatment.

The following shows the five factors and the items with the highest loadings on each of these factors. The 25 scale items were selected from an original pool of 40, on the basis of a factor analysis conducted on data from a sample of 140 therapy clients obtained over a period of four years.

Factor analytic research can be used to collapse scales, reducing items without any significant loss of information. Shortened forms impose less of a burden on the recipients, and are therefore expected to yield higher response rates. On-site evaluation provides clinicians with immediate feedback on their clients' expectations of treatment.

Normalization

I want to find out if I have a serious problem.

I hope to discover that my feelings aren't very unusual.

I want to learn whether other people have problems like mine.

I need to know if I'm the only one going through this.

I want to find out if my problems are common.

Analysis

I hope therapy will increase my understanding of why I do things.

I want to know the reasons behind my actions and feelings.

I need help in understanding how my childhood influenced me.

I hope to figure out what makes me tick.

I hope to learn to be more honest with myself.

Feelings

I hope to feel less anxious and depressed.

I want to feel more positive about myself.

I need to learn how to relax and have more fun.

I want to learn how to prevent becoming depressed.

I need to learn how to keep from getting too angry.

Decision-Making

I want to be able to make the right choice about what to do.

I need help in learning how to make better decisions.

I need help in deciding what to do with my life.

I need some practical advice about a choice I'm facing.

I want to figure out the course that will make me most happy.

Behavior Skills

I hope to learn how to handle situations more competently.

I want to have more confidence that I can do things.

I need help in learning how to be more assertive.

I hope to learn how to be more effective in relating to others.

I want to learn how to get along better with my family now.

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